PRINTED: 07/09/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS354AGC 07/08/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3398 BANCROFT CIRCLE SACHELE SENIOR GUEST HOME LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 7/8/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for six Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness, one Category I resident and five Category II residents. The census at the time of the survey was three. Three resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of C. The following deficiencies were identified: Y 072 449.196(3) Qualications of Caregiver-Med Y 072 SS=E Training NAC 449.196

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

must:

3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver

(a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with

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This Regulation is not met as evidenced by: Based on record review on 7/8/09, the facility failed to ensure 1 of 3 caregivers had background checks completed (Employee #1). Employee #1 does not have state or FBI background checks, and the fingerprints have not been submitted.

Scope: 2

Severity: 2

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NAC 449.2742

6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be

administered to a resident:

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administration of medication, a physician must be notified within 12 hours after the dose is refused

or missed.

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This Regulation is not met as evidenced by: Based on observation and interview on 7/8/09, the facility failed to destroy medications after they were discontinued, had expired or after a resident

had been transferred for 2 of 5 residents. (Discharged Resident #4 and #5). Expired medications for Discharged Resident #4 were

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NVS354AGC				D. WING		07/08/2009	
SACHELE SENIOR GUEST HOME			3398 BANC	ET ADDRESS, CITY, STATE, ZIP CODE BANCROFT CIRCLE VEGAS, NV 89121			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE		COMPLETE
Y 885	facility failed to destro for Discharged Resid	e caregivers room. The py prescription medication ent #5. ficiency from the 9/10/0 ey.	ions	Y 885			
Y 920 SS=D	0 449.2748(1) Medication Storage			Y 920			
	Based on observation	ot met as evidenced by n on 7/8/09, the facility for 1 of 5 residents in a					

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